TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Baylor Medical Center Carrollton

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-18-0168-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
September 19, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The requestor did not submit a position statement. This review will be based on available information.

Amount in Dispute: $1,584.30

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "…It does not meet the exception criteria at §408.0272. No payment is due."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 26, 2016	0250, 73562, 99284	$1,584.30	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out the time limits for filing medical bills.
3. Texas Labor Code §408.027 details requirements for payment to health care providers.
4. Texas Labor Code §408.0272 details exceptions for untimely submission of claim.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 29 – The time limit for filing has expired
   - 731 – Per 133.20(B) provider shall not submit a medical bill later than the 95th day after the date the service

- 928 - HCP must submit documentation to support exception to timely filing of bill (408.0272). Notification of erroneous submission not included.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Does an exception detailed in Texas Labor Code 408.0272 exist?

Findings

1. The requestor is seeking reimbursement for outpatient hospital services rendered on October 26, 2016 in the amount of $1,584.30. The insurance carrier denied disputed services with claim adjustment reason code 29 – "The time limit for filing has expired," 731 – "Per 133.20(B) provider shall not submit a medical bill later than the 95th day after the date the service," and 928 – "HCP must submit documentation to support exception to timely filing of bill (408.0272). Notification of erroneous submission not included."

   28 Texas Administrative Code §133.20 (b) states in pertinent part,

   > Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided.

Review of the documentation submitted with this request for Medical Fee Dispute Resolution (MFDR) finds:

- UB-04 CMS-1450 Medical bill creation date 030317
- UB-04 CMS-1450 Medical bill creation date 091417

The Division finds the carrier's denial is supported as insufficient evidence submitted to support submission of the medical bill within 95 day deadline.

2. Texas Labor Code §408.0272(b) states in pertinent part,

   > Notwithstanding Section 408.027, a health care provider who fails to timely submit a claim for payment to the insurance carrier under Section 408.027(a) does not forfeit the provider's right to reimbursement for that claim for payment solely for failure to submit a timely claim if:
   >
   > (1) the provider submits proof satisfactory to the commissioner that the provider, within the period prescribed by Section 408.027(a), erroneously filed for reimbursement with:
   >
   > (A) an insurer that issues a policy of group accident and health insurance under which the injured employee is a covered insured;
   >
   > (B) a health maintenance organization that issues an evidence of coverage under which the injured employee is a covered enrollee; or
   >
   > (C) a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits under this title; or
   >
   > (2) the commissioner determines that the failure resulted from a catastrophic event that substantially interfered with the normal business operations of the provider

   Review of the submitted documentation found insufficient evidence to support any of the exceptions listed above apply to the services in dispute. Therefore, the requestor has forfeited their right to reimbursement. No payment is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		October 5, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.